TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Kristy Simank, D.C.

Respondent Name

Berkshire Hathaway Direct Ins

MFDR Tracking Number

M4-26-1964-01

Insurance Carrier's Austin Representative

BOX 6 Stone Loughlin & Swanson LLP

DWC Date Received

March 12, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 14, 2025	Examination to Determine MMI and IR 99456	$199.00	$199.00
	Total	$199.00	$199.00

Requester's Position

"I am disputing underpayment of the attached bill dated 08/14/25 in the amount of $863.00. The payment was $664.00. the bill was calculated based on the Texas Administrative Code Title 28 rule 134.260 ..."

Amount In Dispute: $199.00

Respondent's Position

The Austin carrier representative for Berkshire Hathaway Direct Ins. is Stone Loughlin & Swanson, LLP. The representative was notified of this medical fee dispute on March 16, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 130.1 sets out the requirements for certification of maximum medical improvement and impairment rating.
3. 28 TAC Section 134.260 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a referred doctor.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 95 – Plan procedures not followed.
2. G15 – Pricing is calculated based on the medical professional fee schedule value.
3. P12 – Workers' compensation jurisdictional fee schedule adjustment.
4. U00 – There was no UR procedure/treatment request received.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's reduction based on utilization review supported?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking an additional reimbursement of $199.00 for an examination to determine maximum medical improvement and impairment rating as referred by the treating doctor. The insurance carrier reduced payment. DWC will review this service in accordance with applicable rules.

2. The insurance carrier reduced the disputed services stating, "there was no UR procedure/treatment request received."

   Examinations to determine MMI and IR are authorized in accordance with 28 TAC Section 130.1(a)(1), which states,

   (1) Only an authorized doctor may certify maximum medical improvement (MMI), determine whether there is permanent impairment, and assign an impairment rating if there is permanent impairment.

      (A) Doctors serving in the following roles may be authorized as provided in subsection (a)(1)(B) of this section.

         (i) the treating doctor (or a doctor to whom the treating doctor has referred the injured employee for evaluation of MMI and/or permanent whole body impairment in the place of the treating doctor, in which case the treating doctor is not authorized);

         (ii) a designated doctor; or

         (iii) a required medical examination (RME) doctor selected by the insurance carrier and approved by the division to evaluate MMI and/or permanent whole body impairment after a designated doctor has performed such an evaluation.

   The evidence submitted indicates that the examination in question was referred by the treating doctor to determine MMI and IR. DWC finds that the insurance carrier's reduction for this reason is not supported.

3. Because the insurance carrier failed to support its reduction of payment, DWC will review the services for payment in accordance with 28 TAC Section 134.260.

   28 TAC Section 134.260(c) states,

   (c) The following applies for billing and reimbursement of an MMI or IR evaluation by a referred doctor.

      (1) CPT code. The referred doctor must bill using CPT code 99456 with the appropriate modifier.

      (2) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4).

      (3) IR. For IR examinations, the referred doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form …

         (ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4).

The adjusted rate for determination of MMI in 2025 is $465.00. The adjusted rate for determination of IR for one musculoskeletal body area in 2025 is $398.00. The total allowable reimbursement is $863.00. The insurance carrier paid $664.00. An additional reimbursement of $199.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Berkshire Hathaway Direct Ins must remit to Kristy Simank, D.C. $199.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 26, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.